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ABSTRACT

Interest in the health care needs and medical care use patterns of older persons has steadily increased in recent years. The major goals of this study were to describe the variability of health services use by older persons and examine the extent to which specific factors moderate the relationship between life stress exposure and subsequent use of health services. Two groups of older persons (health maintenance organization members and fee-for-service clients) participating in a multi-year panel study comprised the sample. Time-ordered, multivariate analyses of links between life stress exposure, mediating variables, and subsequent use of health services indicate that the process may not be direct nor simple to explain. There were no indications that either social support or increasing age had any direct mediating effects on the time-ordered relationship between life stress exposure and the use of medical care services. However, the interaction of high life stress exposure and low social support was consistently linked to increased rates of health services use. Results are tabulated in five tables and references are included. (Author/TE).

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A PANEL STUDY OF LIFE STRESS, SOCIAL SUPPORT AND THE HEALTH SERVICES UTILIZATION OF OLDER PERSONS

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ABSTRACT

Interest in the health care needs and medical care utilization patterns of older persons has steadily increased in recent years. The major goals of this study were to describe the variability of health services utilization by older persons and examine the extent to which specific factors moderate the relationship between life stress exposure and subsequent health services utilization. Two groups of older persons (health maintenance organization members and fee-for-service clients) participating in a multi-year panel study comprised the study sample. Time-ordered, multivariate analyses of links between life stress exposure, mediating variables and subsequent health services utilization indicate that the process may not be direct nor simple to explain. There were no indications in this study that either social support or increasing age had any direct mediating effects upon the time-ordered relationship between life stress exposure and the utilization of medical care services. However, the interaction of high life stress exposure and low social support was consistently linked to increased rates of health services utilization.

A Panel Study of Life Stress, Social Support
and the Health Services Utilization of Older Persons

INTRODUCTION

During the course of the 1980s, research directed toward the health care needs and medical care utilization patterns of older persons has steadily increased.[1] As various authors[2-3] have noted, the number and proportion of older persons in the American population are continuing to rise. If this demographic trend is in turn associated with greater utilization of medical care providers and hospital services, there is substantial concern that American health care resources will be increasingly strained in future decades.[4]

Numerous types of broad initiatives have been undertaken to help alleviate this concern. These changes have ranged from modification of the Medicare system (such as the introduction of prospective payment of hospital charges) to encouraging older persons to enroll in Health Maintenance Organizations (HMOs) which have a greater interest in health promotion, illness prevention, utilization review and coordination of health care services.

Despite the clearly apparent need to better understand factors that influence utilization of medical care services by older persons, our current level of understanding remains limited by several constraints. For example, there continue to be few reported studies that follow a panel of study respondents over time. This, in turn, severely limits any attempts at causal inference. Also, the issue of how different levels of insurance coverage affect utilization of medical services is typically under-analyzed even though there are important contemporary changes occurring in this domain.[5] Finally, conceptual models that incorporate the effects of exogenous factors such as life stress on health services utilization are still at the developmental stage and many important conceptual issues continue unresolved.[6-7]

The goal of this study was to attempt to contribute to our understanding of how select factors mediate the relationship between elderly life stress exposure and their subsequent health services

utilization. This paper has two specific aims: 1. describe the variability of health services utilization among older persons and 2. examine the extent to which select factors moderate the relationship between life stress exposure and subsequent health services utilization.

Background

What is typically referred to as the Behavioral Model of health services utilization, developed by Andersen and his colleagues,[8-9] has dominated studies of elderly utilization of health care services.[10-14] This conceptual framework contends that there are three major groups of health services utilization determinants: predisposing factors, enabling characteristics, and need for care factors. The first category of hypothesized determinants of health services utilization, predisposing variables, includes three broad types of variables: demographic characteristics, social structural attributes, and health beliefs and attitudes. All of these variables are hypothesized to influence a person's propensity to use services prior to the onset of a specific illness episode. The second group of factors, enabling characteristics, are incorporated into the model to take into account the fact that even if a person is predisposed to using health services, there are certain conditions that will likely facilitate or impede the use of services. Relevant variables within this domain include personal/familial resources, community resources, and awareness and knowledge of available services. The third and final group of variables, need or illness level, includes factors that reflect health problems which directly influence the decision to seek care.

Continued use of the Behavioral Model as a framework for studying older persons' use of health services has resulted in a number of important accomplishments. The breadth of the conceptual model allows investigators to simultaneously examine the impacts of a large number of different types of predictor variables. Studies employing this approach have also often focused on large study samples including a small number that are nationally representative of the entire population of elderly in the American population.[10,14] Finally, the model has been used to study not only the utilization of formal health services provided by doctors, dentists and hospitals but also the use of

services provided by community-level health and social service agencies.[15-17]

In spite of the Behavioral Model's usefulness to health services researchers and its acknowledged value, a series of critical issues have emerged during the last decade concerning its continued refinement. For instance, it has been noted that in spite of the large number of predictor variables that are typically studied, the explanatory power of the model has remained modest.[7] In other words, the vast majority of the variance in utilization behavior remains unexplained. Second, continued reliance on cross-sectional research designs makes it very difficult at a minimum, and impossible at worst, to uncover causal linkages between the predictor variables and utilization behavior.[10] This recognition has heightened the recognized need for panel studies of elderly respondents.[13] There continues to be substantial controversy in relation to how the predictor variables are interrelated and their specific links to utilization behavior.[1,11] It has also been questioned whether the effects of the predictor variables should be analyzed as main-effects (the traditional strategy) or as both main and interactive effects.[18] Another set of issues pertain to the assessment of utilization behavior itself. Various authors contend that a distinction needs to be made between contact vs volume measures of utilization.[1,13] Finally, an increasing number of health services researchers have begun to question whether the traditional distinction of whether a person has health insurance or not is meaningful among the elderly. Since only a small number of older persons are without health insurance, what these authors argue is important is the respondent's type of insurance because it reflects the level of coverage that is available.[5,12]

Ten years ago in his review of studies of physician utilization, Mechanic[19] concluded that there were specific reasons why large-scale multivariate investigations of physician use (frequently based on the Behavioral Model) were limited in their explanatory power. In particular, he argued that researchers needed to improve their measurement of the effects of insurance coverage by including an assessment of the scope of coverage available to the person. This is because the presence of co-payments and deductibles may well serve as economic barriers to physician use. He also suggested that improved understanding of physician utilization would occur if researchers would extend their attention beyond personal attributes and organizational factors to situational contingencies that may

well affect levels of physician utilization. In particular, he hypothesized that increased attention should be directed toward personal life stress exposure and the presence of social supports. Finally, he concluded that since physician visits are the result of a decision-making process, prospective panel studies are needed to unravel processes that unfold over time.

A small number of investigators[6,20-21] appear to have heeded Mechanic's original suggestions and a new perspective on the physician utilization of older people is slowly emerging. The basic intent of this emerging strategy is to unravel the linkage between life stress exposure and the utilization of physician services through an examination of its direct and mediated effects. The approach used in two recent studies exemplify this new approach. One study by Pilisuk, Boylan and Acredolo[21] examined the medical care utilization over a 5 year span of a sample of adult enrollees in a health maintenance organization. Their basic intent was to assess the extent to which social support, age and sex mediate the time-ordered relationship between life stress exposure and subsequent medical care utilization. Results of their study indicated that increased life stress was related to higher subsequent medical care utilization unless moderated by the effects of social support. Another recent study by Krause[6] examined the utilization behavior of a sample of elderly persons. His study focused on the extent to which social support and locus of control mediated the relationship between life stress exposure and subsequent health services utilization. Findings of the study indicated that both social support and locus of control (coping resources) buffered the impacts of life stress on decisions to seek medical care. The results of both of these studies appear to support the contention of Mechanic and other investigators that an increased focus upon life stress exposure and mediating variables may well improve our current ability to explain variability in the use of physician services.

Conceptual Model

The conceptual framework developed for use in this prospective, panel study of elderly utilization of medical care services is displayed in Figure 1.

Figure 1 about here

Its major focus is on the extent to which 4 select mediating variables (social support, socioeconomic status, insurance coverage, and age) moderate the relationship between increased life stress exposure and subsequent change in health services utilization. In accord with previous research in this area,[6,20-21] the authors hypothesize that higher social support will decrease or buffer the effect of increased life stress exposure on increased utilization. Increased age is hypothesized to have the opposite effect. In other words, increased age will heighten the relationship between life stress and change in utilization. Finally, the authors hypothesize that higher respondent SES and more expansive insurance coverage (i.e., lack of financial barriers) will likely augment the relationship between life stress and subsequent change in utilization of services.

The Study

Sample

This study was based on a subset of data collected for a larger project that is investigating the effects of a managed care program on the health beliefs and health-related activities of older persons. Two purposive samples were selected. The first group consisted of elderly enrollees in a staff model health maintenance organization. All 350 elderly enrollees were asked to participate in the study and 258 agreed (74%). A second group consisted of elderly, community-dwelling individuals who lived in the same geographical area as the HMO enrollees but utilized fee-for-service physicians. A total of 324 older persons randomly selected from a list provided by a state agency, who stated during phone interviews that they were not enrolled in an HMO, were requested to participate in the study and 144 agreed (44%). Thus, a total of N=402 older adults age 62 and over volunteered to participate during the first stage of this study. The study sample was totally comprised of older persons living independently in a confined geographic area bordering on the city limits of Chicago. Participants were predominantly female (63%), varied in age from 62 to 93 (MEAN=72.47, SD=5.46), were largely White (97%), and most had earned a high school degree (61%). Sample members had retired from a variety of different types of occupations (managerial/professional (33%), clerical/supervisory (42%), manual/skilled labor (25%)). Fifty three percent of the study subjects were married. Finally, 37% of the sample members had private fee-for-service insurance while the

remainder were HMO enrollees. Eighty six percent of the original sample (N=346) were still in the study six months later during the second stage of data collection. The attrition rate was 15% for FFS respondents and 13% for HMO enrollees. There were no significant differences between those persons who dropped-out of the study vs those who remained.

Research Design

The larger project employed a multi-sample, multi-stage design spread out over three years (1986-1989). The findings discussed in this article are based solely upon data which were collected during the baseline (Winter 1986) and second (Summer 1987) stages of data collection.

Data Collection

Personal interviews were conducted with each study respondent in their residence. Interviews took on average approximately 45 minutes to complete.

Measures

In order to assess change in personal health services utilization over time (the dependent variable), three questions were presented to each respondent at both stages of data collection pertaining to their contacts with the medical care system. On both occasions they were asked to indicate over the last six months: how many times they had seen their personal doctor(s); how many times they had seen a doctor in an emergency care facility; and whether they had spent one or more nights in the hospital during the time period. This type of approach allows for the differentiation of contact vs volume measures of physician utilization which in turn allows for a greater in-depth analysis of changes in utilization.[1] In addition, the reference time period was shorter than the typical one year period that is frequently used but criticized as being too long. [22] Finally, the wording of the specific questions was intentionally identical to that used in other studies of the health services utilization of community-dwelling older persons. [23]

Recent exposure (over the last six months) to stressful life events was measured through the use of a 55 item Significant Life Event Checklist for the Elderly that is designed to assess exposure to a wide range of positive and negative events. The individual's total score is the additive total of items checked.[24] Cronbach's alpha coefficients for the scale at the two stages of data collection were

acceptable (.98 and .70).

Medical need was measured by a multiple-indicator approach due to its acknowledged complexity[25]. Three scales were used to measure : history of vulnerability to disease (alpha=.53), functional capacity- severity of disability (alpha=.71), and functional capacity- dependency level of the person (alpha=.88). Self-assessed health was measured through a question that asked respondents whether they felt that their health was better, worse, or the same as that of other people their age. Life satisfaction was measured via the use of a single question that addressed the respondents' current overall life satisfaction. Two other measures were incorporated as supplementary measures of functional health status. They were the Instrumental Activities of Daily Living (IADL) and Physical Activities of Daily Living (PADL) scales from the Pfeiffer Functional Assessment Inventory.[27]All of the scores from the five scales and two single-item indicators of health status were then combined into one summative, multidimensional measure of medical need (alpha=.74) in order to capture the different elements of this construct. Scale item responses were scored in the direction of better health. Thus, higher scores on the scale are indicative of lower medical need.

The four potential moderating variables were measured as follows. Insurance coverage was categorized as either fee-for-service (0) or HMO (1). Age was based on the report of the respondent. Hollingshead's two-factor measure of social position was used to integrate educational and occupational data into a single measure of socioeconomic status.[28] Five SES levels resulted from this action: low SES, low-middle SES, middle SES, upper-middle SES and upper SES. Finally, social support was measured through the use of a scale (alpha=.62) developed by Asher.[29] There are 12 items in this scale. Four questions pertain to the number of social relationships available to the person (number of persons in the household, number of children not living with the respondent, number of living siblings, and number of spouse's siblings living). The other 8 questions pertain to the frequency of contact that occurs between the respondent and members of his/her social network. Weights are assigned to contact with family and relatives versus contact with members of groups and organizations to reflect the closeness of the social network linkages.

Table 1 displays descriptive data for each of the study variables.

Insert Table 1

Analyses

The project contained several stages of analysis. First, the internal reliability of each of the muiltiple-item scales was assessed. The resultant Cronbach alpha coefficients were reported along with the above description of measures. Second, upon analysis of the distribution of the utilization measures, it became apparent the the measure of personal physician utilization was not normally distributed. For example, most respondents at both time periods reported 0-3 visits with a very few having a large number of visits (outliers) that in turn significantly skewed the distribution. To correct for this maldistribution, the authors first truncated the distribution and then performed a log transformation. Procedures used were identical to those reported by other investgators.[14,23,30] These procedures were only used in conjunction with the volume (vs contact) measure of personal physician utilization. Next, the decision was made to only analyze contact with ER facilities rather than both contact and volume. This was necessary due to the fact that only 13% of the respondents reported such visits during the second stage of data collection and 90% of those individuals reported only one visit (low volume variability). Thus, four measures of utilization were analyzed: contact with personal physician, volume (adjusted) of personal physician visits, contact with ER facilities, and whether the person had experienced hospitalization. The form of the measures was identical at both stages of data collection.

Several observations are also in order regarding the multivariate statistical analyses of the model that were performed. First, although three of the four utilization measures were dichotomous, the decision was made by the authors to estimate the parameters of the model using ordinary least squares (OLS) regression techniques. This straegy is supported by an increasing number of studies that indicate if the split of a dichotomous variable is not excessively severe (greater than .10/.90), OLS results are highly comparable to the results of logistic regression analyses.[1] Second, since the theoretical model in the study hypothesizes that nonadditive effects may be present, interaction

terms were introduced into the analyses to account for variance that may be explained above and beyond that accounted for by the original predictors.[18] The introduction of first-order interaction effects is thus needed to fully test the theoretical model.

Direct association between all of the variables in the model is estimated by their zero-order correlations (Table 2). The data were examined for the presence of serious collinearity prior to the regression analyses but no significant problems were detected. The only excessive (>0.80) correlations identified were between the different types of measures of personal physician utilization (contact and volume).

Insert Table 2

Results

Table 3 shows the extent to which the variables in the study model accounted for change detected in contact with personal physicians and the respondents' volume of utilization. As can be seen upon examination of the table, none of the variables in the model except for previous contact at the earlier stage predicted contact at the second stage of data collection. However, analysis of the volume measure of utilization indicated that three model predictors were significant predictors of increased volume of utilization during the time period under observation (baseline variability is minimized by entering previous level of utilization as the first predictor in the regression analysis). In particular, higher levels of utilization of personal physician services were related to: an interaction effect of higher life stress exposure and lower social support, lower scores on the health measure and lower SES. Thus, higher levels of life stress appear to be positively related to greater use of personal physician services but only when the person has less social support.

Insert Table 3

Next, the model variables were used to attempt to explain variability in the use (contact) of

emergency rooms and other urgent care facilities. As indicated by the results in Table 4, medical need (poorer health) was related to greater contact with ER/urgent care facilities as expected but once again life stress exposure was a significant predictor of the observed change. Higher levels of life stress in conjunction with lower social support were significantly related to increased level of contact with emergency care physicians.

Insert Table 4

The third type of utilization examined focused upon change over time in hospitalization episodes. Once again the intent was to determine the extent to which the study model could explain whether a person experienced a hospitalization episode. As shown in Table 5, the results once again indicate that poorer health or greater medical need is predictive of hospitalization but that the interaction of life stress and lower social support is also a significant predictor.

Insert Table 5

Summary and Discussion

The major intent of this study was to help to continue to unravel the complex relationships between life stress exposure and the health services utilization of older persons. From the onset, the authors hypothesized that changes in patterns of health services utilization over time are affected directly by level of health status and indirectly by life stress exposure. Four potential mediating variables were postulated to be of potential importance - social support, age, socioeconomic status, and type of insurance coverage. In order to minimize regression toward the mean, a common problem in studies of change, the baseline level of each dependent variable was consistently the first variable entered in the regression equations. As would be expected, medical need or level of health status was found to be a consistently significant predictor of changes in utilization behavior. Those individuals with lower health status tended to be higher utilizers. Life stress exposure had no

significant, direct relationship to changes in utilization patterns. Instead, only those individuals with high levels of exposure to stressful life events and a low level of social support from family members, neighbors and associates had increased amounts of utilization. This pattern was consistent across all three types of utilization under study. The observed relationship between life stress exposure, social support and increased health services utilization persisted even when socioeconomic and health differences were controlled statistically. Thus, the inference may be made that a significant component of the increased utilization was actually attributable to the interaction of life stress exposure and low social support.

In addition, a modest yet significant direct effect of socioeconomic status on the volume of personal physician use was evident in this study. Since the relationship between SES and the volume of personal physician visits was negative, it appears that higher use is associated with lower income. This was unexpected since other authors such as Rosner and her colleagues[12] have typically found that SES is positively related to physician utilization. There are several explanations for this finding. First, it may indicate that ability to pay for services as reflected by SES is not a major concern within this sample due to improved health coverage. Another explanation, is that SES may reflect life-style and value differences which may lead to a greater reliance upon personal health-promotion and self-care activities vs reliance upon physicians. Unfortunately, this general issue cannot be addressed in this study.

Findings of this study continue to support Mechanic's contention that the use of health care resources is closely linked to personal life stress exposure and the availability of coping resources. As in the case of two other recent studies [6,21] the persistent finding is that the effect of stressful life events is not direct. Instead, stressful life events appear to lead to increased use of health care services when the elderly person is particularly vulnerable due to a low level of social support from family members, neighbors and associates. This suggests that social support serves as a coping resource to the older person which in turn enables them to cope with stressful life events without resorting to entering the medical care system for assistance. This consistent finding clearly suggests that both of these variables are worthy of continued inclusion in future studies of elderly use of

medical care services.

The results of the study also suggest that older persons with less social support and coping resources may be turning to physicians for not only assistance with medical problems but also help with psychosocial issues. The HMO examined in this study did not provide such assistance through ancillary service providers such as psychologists or social workers. Nor could individuals who were under the care of fee-for-service physicians obtain such services without cost. If utilization of physicians for such a reason is viewed as "inappropriate" this suggests that such support services may be needed at the community level to decrease use of physicians for such a purpose and constrain "unnecessary" physician utilization. In other words, the provision of counseling services and other support programs may be a useful adjunct to physician services.

A number of shortcomings that were present in earlier studies of life stress, social support and physician use were specifically addressed in this study. First, since this was a panel study and measures of health services utilization were available at multiple time points, it was possible to actually examine the amount of change that occurred and to link the change to a select group of potential predictors. Second, the temporal lag (6 months) incorporated into the study minimized the likelihood that other extraneous factors may have affected use of health services. And third, interaction effects were purposefully incorporated into study analyses in order to test the complete model proposed by the authors. Nevertheless, there are are also certain methodological issues which need to be acknowledged. Mainly, the sample analyzed in this study was not randomly selected from a determinate population. As a result, the generalizability or external validity of the study's findings are questionable. In addition, since the data were all based upon the self-reports of respondents, caution must be exercised.

Future studies of life stress, social support and the use of health services among the elderly might offer improved predictive accuracy through both conceptual and methodological changes. For example, the mediating effects of sex and health locus of control need to be determined. It may be that males and females respond differently to life stress exposure, have different types of social networks and, as a result, they exhibit different types of use patterns. In addition, persons with an

internal health locus of control and a strong social support system may have particularly low rates of physician use.[20] Needed methodological improvements should include sample panels that are representative of a determinate population and improved methods to validate self-reports of health services utilization.

When combined with the findings of other studies of life stress, social support and the use of health services, an advance in our general understanding of the determinants of health services utilization of older persons is evident. Evidence is slowly accumulating that supports Mechanic's original observation that the successful explanation of health services utilization is at least partially contingent upon our understanding the situational contingencies that face study respondents. Continued improvements in theoretical approaches and study methodologies will hopefully enhance our future understanding of this complex issue.

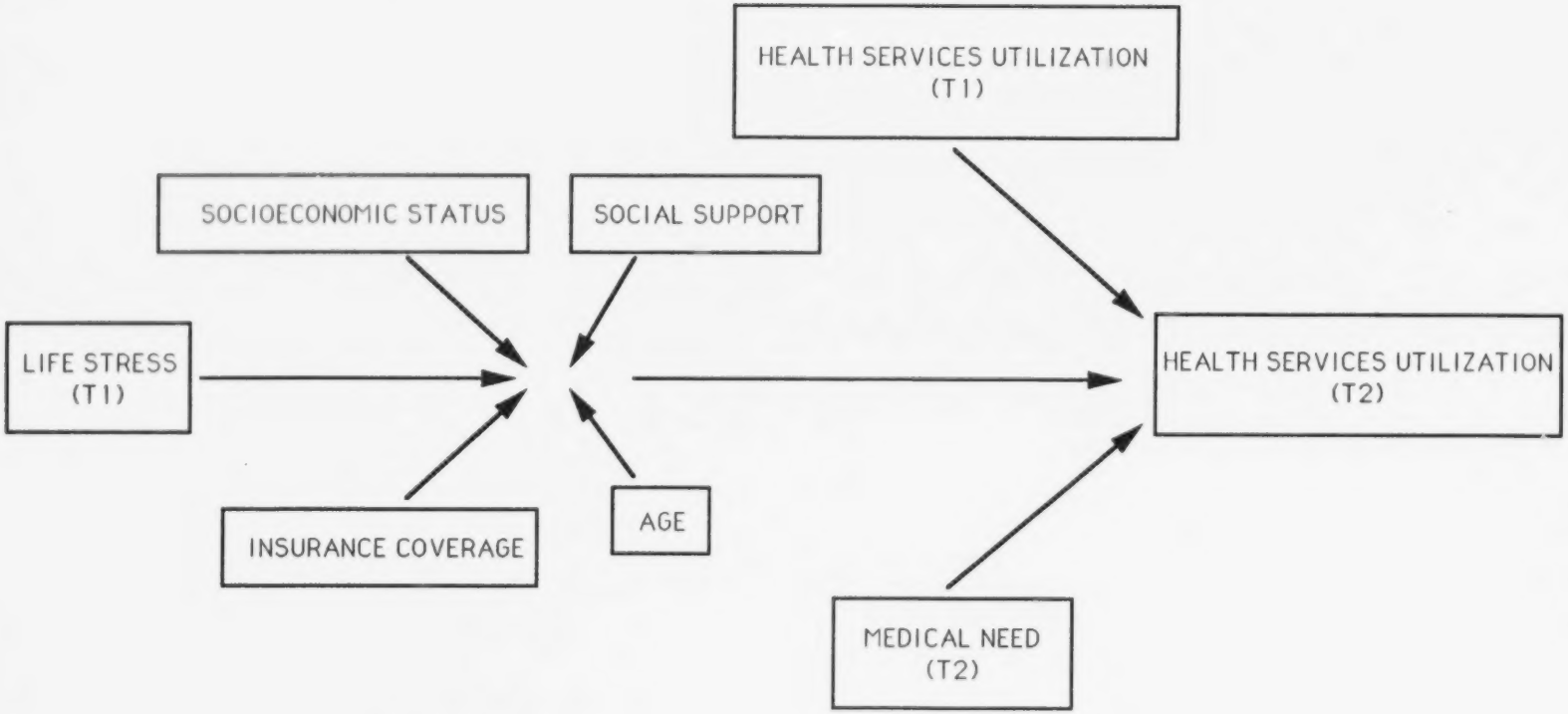

Fig. 1. Conceptual model of life stress and health services utilization.

Table 1. Sample Description

Variable	Mean	S.D.	Range (Min/Max)
Life Stress	4.75	2.56	(0/14)
Social Support	39.04	12.01	(7/68)
Age	72.47	5.45	(62/93)
Medical Need	56.51	6.40	(0/64)
SES	3.98	1.08	(1/5)
HMO Health Insurance	63%		
FFS Health Insurance	37%		
Personal Doctor Visits[a]			
Contact (T1)	82%		
Volume (T1)	3.16	2.30	(1/9)
Contact (T2)	73%		
Volume (T2)	3.17	2.38	(1/9)
ER Doctor Visits[b]			
Contact (T1)	12%		
Contact (T2)	11%		
Hospital Episode(s)[c]			
(T1)	12%		
(T2)	11%)		

[a]The measure of volume was truncated with visits > 9 coded as 9.

[b]No measure of volume is included due to lack of variability.

[c]Respondents were asked if they had been hospitalized but not how many times.

Table 2. Correlation Matrix of All the Variables in the Model

	X1	X2	X3	X4	X5	X6	X7	X8	X9	X10	X11	X12	X13	X14
X1	___													
X2.	12[b]	___												
X3	-.11[b]	-.16[a]	___											
X4	.11[b]	.06	-.01	___										
X5	.14[a]	.02	-.03	.21[a]	___									
X6	.09	.17[a]	-.25[a]	.07	-.19[a]	___								
X7	.06	-.10	.10	-.03	-.06	-.09	___							
X8	.11[b]	.02	.03	.04	.07	-.19[a]	.99[a]	___						
X9	.05	-.01	.02	-.01	-.07	-.08	.45[a]	.09	___					
X10	.03	.02	.06	-.13[b]	-.05	-.12[b]	.08	.08	.99[a]	___				
X11.	.21[a]	.02	.02	-.06	.05	-.16[a]	.14[a]	.11	.13[b]	.13[b]	___			
X12	.15[a]	-.01	-.03	-.03	.07	-.19[a]	.04	.06	.14[a]	.36[a]	.24[a]	___		
X13	.18[a]	-.08	.11[b]	-.06	.12[b]	-.19[a]	.15[a]	.33[a]	.05	.17[a]	.38[a]	.09	___	
X14	.14[a]	-.06	.05	.04	.03	-.23[a]	.12[b]	.11[b]	.12[b]	.41[a]	.24[a]	.36[a]	.33[a]	___

Table 2. Correlation Matrix of All the Variables in the Model (cont'd)

X1 = life stress; X2 = social support; X3 = age; X4= SES; X5= insurance type; X6 = medical need; X7 = contact personal doctor (T1); X8 = volume personal doctor (T1); X9 = contact · personal doctor (T2); X10 = volume · personal doctor (T2); X11 = contact = ER doctor)T1); X12 = contact · ER doctor (T2); X13 = hospital episode (T1); X14 = hospital episode (T2).

[a]p < 0. .01.

[b]p < 0. .05.

Table 3. Predictors of Change in Personal Physician Visits

Predictor Variable	R	R^2	Beta	F	Predictor Variable	R	R^2	Beta	F
Contact (T1)	.42	.17	.39	83.88[a]	Volume (T1)	.35	.12	.32	48.29[a]
					Life Stress * Support	.38	.14	.14	9.85[b]
					Medical Need (T2)	.40	.16	-.11	5.49[c]
					SES	.41	.17	-.12	5.32[c]

[a] $P < 0.001$.

[b] $P < 0.01$.

[c] $P < 0.05$.

Table 4. Predictors of Change in ER/Ambulatory Care Facility Visits

Predictor Variable	R	R^2	Beta	F
Contact (T1)	.21	.05	.21	15.03[a]
Medical Need (T2)	.27	.07	-.17	12.34[b]
Life Stress	.29	.09	.12	5.75[c]

[a] $p < 0.001$

[b] $p < 0.01$

[c] $p < 0.05$

Table 5. Predictors of Change in Hospital Episodes

Predictor Variable	R	R^2	Beta	F
Hospital Episode (T1)	.29	.09	.29	28.52[a]
Medical Need (T2)	.35	.12	-.19	15.04[a]
Life Stress * Support	.38	.15	.16	12.56[c]

[a] $p < 0.001$

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